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Health care is a uniquely personal and value-laden service that people often receive in a condition of great anxiety and vulnerability. Therefore, we hope that the corporations that deliver this service care for us personally, rather than see us only as a means to make money. Many people will initially react that a "caring corporation" is an oxymoron, so let me begin by defining what I think that this might mean. I take the term "care" to mean a feeling or attitude rather than an action. Thus, care does not simply mean the mechanistic aspects of delivering medical services as in the phrase, "health care delivery system." Instead, it means delivering health care with a caring attitude—as in the contrast between "caring and curing."[2] In short, the question is whether health care corporations can be expected to have a genuine concern for the well-being of their customers and communities, rather than treating health care purely as a business transaction.

Care matters because in every corporate environment, various mechanisms of legal oversight exist to protect against opportunistic behavior and to promote social objectives. Legal controls, however, invite corporations to follow only the letter and not the spirit of the law and to follow the letter of the law only so far as it is likely to be enforced. Rather than trying to police all possible forms and instances of circumvention, it would be more efficient to foster a corporate culture or climate that motivates behavior consistent with public policy.[3] This analytical point is one of the major insights of the social norms branch of legal scholarship.[4] People refrain from littering and help out their neighbors in need not because the law requires it, but in response to social norms. The same can be true for corporations.[5] A culture of caring about the right set of goals

and outcomes can be a more powerful and systemic influence on corporate behavior and attitudes than any overtly regulatory regime.

In medicine there are strong reasons to value an ethic of caring. The vulnerability of patients and the suffering caused by illness create imperative moral conditions that compel an ethic of compassion.[6] Traditionally, this morality has been fostered through the professional ethics that apply to individual physicians and nurses. Now that health care delivery has become "corporatized," we must also look to institutions for ethical attributes of caring. We might have good reasons to be deeply skeptical of whether this is feasible for reasons captured in the historical prohibition of the "corporate practice of medicine."[7] In prior eras, it was thought that the ethical and compassionate practice of medicine was inherently incompatible with the profit orientation and bureaucratic rationality of corporations, which, in the words of one court, "tend to debase" the ethics of the profession.[8] Despite these concerns, however, we have come to accept the necessity, or at least the inevitability, of the corporate dominance of health care delivery.[9] Therefore, we desperately hope that the basic rationale for the corporate practice prohibition is wrong and hope that health care corporations can foster an ethic of caring.

Any discussion of corporate character confronts the problem that I call the anthropomorphic fallacy—namely, falsely assuming that corporations have a human identity and personality traits. To be caring requires empathy, intentionality, and other traits that are uniquely sapient.[10] It would make no sense, for example, to say that my pencil cares about what it writes. Similarly, to have an "ethic" of care assumes a moral status that is uniquely human. We might say that an animal is caring, like the way that a mother dog cares for her puppies, but it would be a misuse of the term to assert that a dog has an "ethic" of care. Therefore, if objects never care, and only humans have an ethic of care, does it make any sense to ask whether a corporation can have an ethic of care? After all, corporations, as abstract

legal constructs, have lower ontological status than either objects or animals.

This problem may be a fascinating conundrum for philosophers,[11] but as a practical problem it poses no great difficulties for this discussion.[12] There is a simple solution to the riddle of corporate personality, which is known to every lawyer: corporations are bundles of agency and contractual relationships among real individuals. Thus, when we refer to corporate personality traits, we are speaking about the collective traits of the individuals who act on behalf of the corporation. This, however, is no more a philosophical or practical puzzle than to speak about the ethics of a profession. Strictly speaking, perhaps it is correct that only individuals can be ethical or not ethical, but the collective attitudes and behaviors of a group of lawyers or doctors can sensibly be attributed to the construct of a profession, and likewise, for the individuals that make up corporations.

I. THE RELEVANCE OF PROFIT STATUS

Moving beyond the philosophical and definitional obstacles, we next explore what it may take for a health care corporation to be caring. First, it is necessary to consider the relevancy of nonprofit status. The major advantage of the nonprofit form is that corporate objectives tend to be defined in terms of having a substantive mission instead of simply making as much money as possible.[13] Having a substantive mission does not make profits irrelevant, but profits become a means to an end rather than an end in itself; this notion is captured in the phrase "not-FOR-profit." The title, "nonprofit," however, is often a misnomer because nonprofit hospitals and health plans often generate very large surpluses. But, they are still not-FOR-profit in the sense that this is not the reason for their existence.

For-profit companies also have mission statements that seek to guide their corporate culture, but at least for publicly traded companies, we have to assume that the substantive mission is secondary to the goal of an increasing return on an equity investment. If another mission would

generate greater profits, nothing in principle should give a for-profit company pause about changing its substantive focus. Nonprofit companies, however, tend to stick to their mission and treat it more seriously as their main purpose for existence.

This does not necessarily mean that nonprofit corporations care more, or that for-profit corporations less. Successful profit-maximizing firms often find that it is in their interest to care deeply about their customers. Federal Express, for instance, genuinely cares about whether its packages arrive on time as depicted by Tom Hanks in the movie *Castaway*. Developing that corporate culture has been a huge commercial success, and I am certain that the same is true for many for-profit hospitals, nursing homes, and health insurers.

Simply because an organization is nonprofit does not guarantee that it will be a caring institution; instead, care depends entirely on what the mission is and how it is executed. If the mission is to sell as much health insurance as possible, the institution may care only enough to accomplish that goal. In fact, caring less in some ways may better advance an organization's goals in other ways. For instance, health insurers sell more insurance by adopting strict underwriting rules and perhaps by imposing more onerous utilization review. These are steps that many people would view as uncaring, but these steps have been taken by nonprofit health insurers in order to better pursue their missions.[14] This is precisely why health insurers are called health plans or managed care organizations, rather than health caring organizations. They are imbued with a rational, calculating character that is focused on hard performance measures and production processes. In short, they are all about curing in an objective sense and not necessarily about caring in a subjective, emotive sense.

II. INTERNAL CODES OF ETHICS AND COMPLIANCE PROGRAMS

We should go beyond profit status and look for other means to promote a caring culture within health care corporations. One good strategy might be

to encourage health care institutions to adopt internal codes of ethics that foster a corporate ethos and guide their employees' behavior. This approach to corporate responsibility is being pursued both under the federal sentencing guidelines for criminal conduct and under SEC rules pursuant to the Sarbanes-Oxley Act.[15] These laws encourage corporations to adopt ethics codes, and it is expected that this will soon become nearly universal among publicly traded companies. Codes of ethics are already common in the health care sector.[16] They have existed in hospitals for decades, and managed care codes of ethics have been adopted by health insurers over the past decade in response to public concerns about their trustworthiness. Similar to ethics codes are corporate-compliance programs, which have proliferated in health care institutions over the past decade in response to heightened scrutiny by regulators and prosecutors.[17]

Ethics codes and compliance programs are good starting points, but these alone are not likely to produce the heartfelt commitment that we are hoping for. Ethics codes and compliance programs are too easily displayed as window dressings that are honored only through lip service without any sincere efforts to inculcate their principles in the thinking and behavior of management and employees.[18] In the reasoned view of one skeptic, ethical codes are not necessary for those who are truly motivated to behave ethically, and for those who are not well motivated, codes are ineffective.[19] After all, even Enron had a Code of Business Ethics and a set of widely-announced corporate values that included "respect" and "integrity."[20]

III. Measuring and Reporting Care

Although ethics codes can do some good, they are like the structural measures of quality historically used for health care licensure and accreditation, which provide only limited assurance of meaningful performance.[21] Therefore, taking a clue from the field of health care quality measurement, I propose that the best way to foster a caring culture is by objectively measuring and reporting the ultimate outcome in which we are

interested. If caring could be measured in some fashion, then corporations could be rated and compared based upon their cultures of caring. Measuring care would provide managers with a metric upon which they could focus. This would make it more feasible for managers to care about caring and to ultimately do something about it. My proposal goes beyond others,[22] however, by using measures of caring as more than a tool for strictly internal management. Thus, I propose making caring a visible basis for comparison among competing organizations.

Because health care institutions are so acutely conscious of their reputations, comparing corporations based on their cultures for caring has the potential to work wonders.[23] This acute sensitivity to corporate reputations creates a unique opportunity to use market mechanisms to promote socially desired goals. Although this strategy works reasonably well for reputations regarding the quality of care,[24] the market forces bearing on reputations for caring are imperfect. Hospitals, for instance, compete primarily for physicians, not directly for patients. Moreover, there are reasons to suppose that physicians are imperfect agents for a patient's desire to have compassionate nurses. Generally speaking, physicians care more about efficiency and technical competency than about the emotive aspects of a patient's experience. Therefore, hospitals that promote themselves based on the caring quality of their nursing staff will receive only limited rewards for their efforts. Instead, competitive pressures bearing on hospitals may tend to promote less, rather than more, caring by the nursing staff.

This lack of market incentive to foster a reputation for caring is similar to other kinds of market defects that health economists have noted restrict information about the quality of products or services.[25] The solution for health care is the same as the solution for consumer products—to encourage or to require better production and dissemination of information about the characteristic of interest. In the health care sector, there are numerous points of leverage for amplifying or steering market forces in more socially

desired directions. For example, mechanisms of accreditation, standards for tax exemption, conditions for participation in Medicare, and direct regulation of hospitals and health insurers would all amplify and steer the market in a more socially conscious direction.

One example of how these mechanisms have been used to address the general corporate ethos relates to the amorphous concept of "community benefit" under charitable tax exemption laws. In the 1980s, the tax exempt status of nonprofit hospitals came under attack because of the low level of true charity care that they were delivering beyond merely absorbing the bad debts and contractual discounts that all hospitals incur.[26] To fortify the argument that hospitals deserve an exemption for community benefits other than charity care, several leaders in the voluntary hospital sector formulated an inventory of community benefits that served as a template for what nonprofit hospitals should be doing in areas such as public education, community representation on the board of trustees, and maintaining a full range of services.[27] This helped to focus the attention of nonprofit managers on advancing these dimensions of community orientation.

Doing something similar for the amorphous concept of caring might create a strong incentive for managers to foster a culture of caring. After all, no health care institution wants to be known as uncaring or as less caring than its competitors. We see this strategy already working with the widespread use of satisfaction measures; it is now commonplace to receive satisfaction surveys from all sorts of providers both within and outside of health care. Purchasers, managers, and regulators have all found that measuring and reporting satisfaction is a strong motivator to improve service quality.

The same can be true for constructs as subjective and interpersonal as caring. Questions about caring are already often part of satisfaction surveys.[28] They are also a part of a validated research tool to measure the ethical climate of corporations.[29] A research team at Wake Forest University has developed several scales that rate trust in physicians and

health insurers.[30] Trust is an ethical and interpersonal construct that is closely akin to caring, and several of the items in these trust scales refer specifically to caring.[31] These measures have been tested, validated, and have been shown to have a strong psychometric reliability; they are now being widely used by institutions and physician groups to evaluate and to improve relationships with patients.

The next step would be to further develop and standardize the components of the measures that refer to caring. Among other tasks, this would require agreeing on what the principal objects of caring should be for different types of health care organizations. For instance, these organizations might be expected to care not only about their customers but also about their communities. For each of these points of reference, it is necessary to make a decision about what these organizations should be expected to care about. These will be difficult issues to resolve, but if a general consensus can be reached, then the technical task of reducing these goals to a practical survey measure can be readily accomplished. Moreover, health care organizations could be encouraged or required by various means to report their caring scores.

One major objection to the survey approach is that there are many attributes that we expect from health care corporations in addition to caring, such as competency, customer service, and community benefits. In order to focus reputational pressures and institutional resources, corporations are required or are asked to report on the various measures of competency, customer service, and community benefits. However, we can't expect corporations to give every dimension heightened attention. Each new request for measurement and reporting competes with the other measurements, and at some point, the efficiency starts to erode. Therefore, we may need to decide whether we really care enough about caring to measure it. A potential solution to this dilemma is that caring is easily included as one component of other important measures that are already being taken.

Another potential objection to the idea of measuring care is that surveys will encourage cynical manipulation of people's responses by adopting an insincere appearance of caring.[32] I am reminded, for instance, about how businesses sometimes manipulate customer satisfaction surveys by subliminally or overtly priming their customers to give their highest ratings.[33] Certainly, this kind of manipulation is offensive, but these business managers also make similar efforts to drill the mantra of customer satisfaction into the minds and work habits of their employees. Sincere or not, employees of well-managed companies are cheerful, helpful, and attentive. Customers feel cared for and, in fact, are well cared for. Just as professors might attempt to improve their teaching by receiving student evaluations, does it really matter that much whether improved customer satisfaction happens through strategic manipulation rather than from the true goodness of a corporation's heart?

The same cynicism might also be applied to a physician's bedside manner. There is vast literature on which styles of communication, which forms of body language, and other elements of patient-physician interaction best put a patient at ease by respecting his or her humanity, increasing his or her trust, and improving his or her satisfaction ratings.[34] But, we do not think that it is wrong or manipulative to teach physicians with poor innate communication skills how to improve their bedside manner. Instead, we believe that practicing behaviors that display care and empathy will in fact genuinely foster those attitudes. Thus, what begins as a strategic routine becomes a habit and grows into a genuine ethic. In this way, genuine caring can result from bureaucratic rationality and strategic planning.

In summary, if we care about caring, we should measure caring. Doing this would give corporate managers the information upon which they need to focus, but more importantly, reporting caring scores to customers and to the public would greatly motivate health care corporations to adopt and promote a genuine ethic of caring.

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[2] *See* Rand E. Rosenblatt, *Health Care, Markets, And Democratic Values*, 34 VAND. L. REV. 1067, 1092 (1981). *See also* CARING AND CURING: HEALTH AND MEDICINE IN THE WESTERN RELIGIOUS TRADITIONS (D.W. Amundsen & R.L. Numbers eds., 1986); NANCY MOORE & HENRIETTA KOMRAS, PATIENT-FOCUSED HEALING: INTEGRATING CARING AND CURING IN HEALTH CARE (1993).

[3] *See* Lynne L. Dallas, *A Preliminary Inquiry into the Responsibility of Corporations and their Officers and Directors for an Ethical Corporate Climate: The Psychology of Enron's Demise*, 35 RUTGERS L.J. 1 (2003).

[4] On social norms and the law, see ERIC A. POSNER, LAW AND SOCIAL NORMS (2000); Richard H. McAdams, *The Origin, Development, and Regulation of Norms*, 96 MICH. L. REV. 338 (1997); Robert D. Cooter, *Decentralized Law for a Complex Economy: The Structural Approach to Adjudicating the New Law Merchant*, 144 U. PA. L. REV. 1643 (1996); Robert Cooter, *Do Good Laws Make Good Citizens? An Economic Analysis of Internalized Norms*, 86 VA. L. REV. 1577 (2000); Robert C. Ellickson, *Law and Economics Discovers Social Norms*, 27 J. LEGAL STUD. 537 (1998).

[5] *See* Mark A. Hall, *Legal Rules and Industry Norms: The Impact of Laws Restricting Health Insurers' Use of Genetic Information*, 40 JURIMETRICS J. 93, 120–22 (1999).

[6] Lois Shepherd, *Face To Face: A Call For Radical Responsibility In Place Of Compassion*, 77 ST. JOHN'S L. REV. 445 (2003).

[7] *See* Joseph Laufer, *Ethical and Legal Restrictions on Contract and Corporate Practice of Medicine*, 6 LAW & CONTEMP. PROBS. 516 (1939).

[8] Bartron v. Codington County, 2 N.W.2d 337 (S.D. 1942). The court elaborated: "The end results seems inevitable to us, viz., undue emphasis on mere money making, and commercial exploitation of professional services." *Id.* at 346.

[9] *See* Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 506–18 (1988); Jeffrey F. Chase-Libitz, Note, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445 (1987).

[10] One court, for instance, explained that "[t]he qualifications [to practice a profession] include personal characteristics such as honesty, guided by an upright conscience and a sense of loyalty to clients or patients. . . . No corporation can qualify. It can have neither honesty nor conscience." Dr. Allison, Dentist, Inc. v. Allison, 196 N.E. 799, 800 (Ill. 1935).

[11] *See* Peter French, *The Corporation as a Moral Person*, 16 AM. PHIL. Q. 207 (1979).

[12] *See* Stanley Joel Reiser, *The Ethical Life of Health Care Organizations*, HASTINGS CENTER REP., Nov.–Dec. 1994, at 28, 29.

[13] *See id.*; BRADFORD D. GRAY, THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS 112 (1991); THE NONPROFIT SECTOR: A RESEARCH HANDBOOK (Walter Powell ed., 1987).

[14] *See* STEVEN D. PEARSON ET AL., NO MARGIN, NO MISSION: HEALTH-CARE ORGANIZATIONS AND THE QUEST FOR ETHICAL EXCELLENCE (2003).

[15] *See* Notes, *The Good, the Bad, and their Corporate Codes of Ethics: Enron, Sarbanes-Oxley, and the Problems with Legislating Good Behavior*, 116 HARV. L. REV. 2123 (2003).

[16] *See* PEARSON ET AL., *supra* note 14, at 27–31.

[17] Information about compliance programs can be found at Office of Inspector General of the U.S. Dept. of Health and Human Services & American Health Lawyers Association, *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors* (2003), *at* http://oig.hhs.gov/fraud/docs/complianceguidance/040203CorpRespRsceGuide.pdf (last modified Apr. 2, 2003). *See also* John F. Fatino, *Corporate Compliance Programs: An Approach to Avoid or Minimize Criminal and Civil Liability*, 51 DRAKE L. REV. 81 (2002); Thomas E. Bartrum & L. Edward Bryant, *The Brave New World of Health Care Compliance Programs*, 6 ANNALS HEALTH L. 51 (1997).

[18] *See* Dallas, *supra* note 3.

[19] *See* Notes, 116 HARV. L. REV. 2123, *supra* note 15.

[20] Dallas, *supra* note 3, at 51.

[21] *See* TROYEN BRENNAN & DONALD BERWICK, NEW RULES: REGULATION, MARKETS AND THE QUALITY OF AMERICAN HEALTH CARE (1996).

[22] *See* Dallas, *supra* note 3.

[23] *See* William M. Sage, *Reputation, Malpractice Liability, and Medical Error*, *in* ACCOUNTABILITY: PATIENT SAFETY AND POLICY REFORM (Virginia A. Sharpe ed., 2004).

[24] *See* Jack A. Meyer et al., *Report on Report Cards: Initiatives of Health Coalitions and State Government Employers to Report on Health Plan Performance and Use Financial Incentives* (Economic and Social Research Institute, Mar. 1998), *available at* http://www.esresearch.org/Documents/reportcard.html (last visited Oct. 30, 2004).

[25] *See* Wesley Magat, *Information Regulation*, *in* 2 THE NEW PALGRAVE DICTIONARY OF ECONOMICS AND THE LAW 307 (Peter Newman ed., 1998); Michael Fishman & Kathleen Hagerty, *Mandatory Disclosure*, *in* 2 THE NEW PALGRAVE DICTIONARY OF ECONOMICS AND THE LAW 605 (Peter Newman ed., 1998).

[26] *See* Mark Hall & John Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307 (1991).

[27] *See* J. David Seay & Bruce C. Vladeck, *Mission Matters*, *in* IN SICKNESS AND IN HEALTH: THE MISSION OF VOLUNTARY HEALTH CARE INSTITUTIONS (J. David Seay & Bruce Vladeck eds., 1988).

[28] *See* DAVID WILKIN ET AL., MEASURE OF NEED AND OUTCOME FOR PRIMARY HEALTH CARE 257 (1992) ("This doctor really cares about me as a person"); Dana Safran et al., *The Primary Care Assessment Survey: Tests Of Data Quality And Measurement Performance*, 36 MEDICAL CARE 728, 739 (1998) ("[your] doctor's caring and concern for you"); John E. Ware, Jr. et al., *Defining and Measuring Patient Satisfaction With Medical Care*, 6 EVALUATION & PROGRAM PLAN 247, 253 (1983) ("Doctors don't care if their patients worry").

[29] Bart Victor & John B. Culler, *The Organizational Bases of Ethical Work Climates*, 33 ADMIN. SCI. Q. 101 (1988).

[30] Mark A. Hall et al., *Measuring Patients' Trust in Their Primary Care Providers*, MED. CARE RES. & REV., Sept. 2002, at 293, 312–13; Beiyao Zheng et al., *Development of a Scale to Measure Patients' Trust in Health Insurers*, HEALTH SERV. RES., Feb. 2002, *available at* http://www.findarticles.com/p/articles/mi_m4149/is_1_37/ai_84879863 (last visited Oct. 30, 2004); Mark A. Hall et al., *Trust in the Medical Profession: Conceptual and Measurement Issues*, 37 HEALTH SERVS. RES. 1419, 1423 (2002); David H. Thom et al., *Measuring Patients' Trust in their Physicians When Assessing Quality of Care,* HEALTH AFF., Jul. 2004, at 124.

[31] The insurer trust scale asks: "Does your health insurer care more about saving money than about getting you the treatment you need?" *Development of a Scale*, *supra* note 30. The medical profession scale asks: "[Do] [d]octors care about their patients' health just as much or more as their patients do?" *Trust in the Medical Profession*, *supra* note 30, at 1425. The physician trust scale asks: "Does your doctor sometimes care more about what is convenient for him or her than about your medical needs?" *Measuring Patients' Trust*, *supra* note 30, at 301.

[32] Professor Rob Gatter, for example, comments that if hospitals are compared based on measures of patient trust, "it is not hard to imagine the advertising campaign: '*ABC Hospital System: voted by patients as the most trusted hospital system in the state!*'" Robert Gatter, *Faith, Confidence and Health Care: Fostering Trust in Medicine Through Law*, 39 WAKE FOREST L. REV. 395, 427–28 (2004).

[33] For instance, when I took my car into the dealer for an oil change a couple of weeks ago, there were large, colorful signs plastered on the walls saying, "our goal is *total* satisfaction." Two days later, I received a phone call from a very pleasant sounding customer service representative asking whether there was "anything you were not *totally* satisfied with"? These events were intended to convince me to give a "totally satisfied" answer to the satisfaction survey I would receive in the mail a week later from a third-party survey firm. By repeating the mantra of "total satisfaction," and giving me every opportunity to speak up if I wasn't totally satisfied, the car dealer was trying to manipulate the survey assessment so that almost all of its customers would give it the highest rating. In fact, this particular dealer boasts in its advertising that it has the highest customer satisfaction ratings in the southeast.

[34] *See, e.g.*, Moira A. Stewart, *Effective Physician-Patient Communication and Health Outcomes: A Review*, 152 CAN. MED. ASSOC. J. 1423 (1995).